STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 00 B. WING	09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER	5233 ROSEBUD LANE NEWBURGH, IN47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a recertification and state licensure survey. This visit included the investigation of complaint number IN00096312. Complaint number: IN00096312 Substantiated, Federal/State deficiencies related to the allegations are cited at F323. Survey dates: September 21, 22, 23, 26, 27, 28, 29, 2011 Facility number: 011049 Provider number: 155670 AIM number: 200258520 Survey team: Diane Hancock, RN TC Amy Wininger, RN Census bed type: SNF/NF 110 Total 110 Census payor type: Medicare 23 Medicaid 58 Other 29 Total 110 Sample: 22	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/3/11 Cathy Emswiller RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure residents with contractures had splints applied according to the plan of care (Residents #31 and #48), one resident with a Peripherally Inserted Central Catheter [Picc] line had the dressing changed as ordered (Resident 43), and a resident receiving insulin was free of a significant medication error, in that Resident #31 and Resident #48 had carrot splints ordered, but not applied for 2 of 2 residents sampled for splint use, Resident #43 had a Picc line dressing change ordered weekly and it was not performed for 1 of 2 residents sampled for IV dressing change, and Resident #14 had insulin ordered at bedtime and it was not given for 26 days, for 1 of 2 residents sampled for receiving insulin in a facility	F0282	**F282** **AngelRiverHealth and Rehabilitation** **Plan of Correction** **Annual/Complaint Survey** **Date: September 21, 2011** **IndianaStateDept of Health** **Tag F 282** **Corrective action implemented for those residents found to have been affected** **For resident's #'s 31 and 48 care plans and Certified Nursing**	10/24/2011

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	sample of 22. Findings include: 1. A. The clinical record of Resident #31 was reviewed on 09/27/11 at 3:40 P.M. The record indicated diagnoses included, but were not limited to, dementia and bone and cartilage disorder. The record further indicated Resident #31 was receiving Hospice services. Resident #31 was identified, on 09/21/11 11:35 A.M., during the initial tour by UM [Unit Manager] #1 as not interviewable and "having problems with her hands". Resident #31 was observed, at that time, to be lying in bed with two carrot splints lying at her side, her bilateral hands were observed to be contracted. Resident #31 was observed, on 09/27/11 at 11:10 A.M., up in a wheelchair with no carrot splints in her hands. Resident #31 was observed, on 09/27/11 at 5:15 P.M., sitting in a geri-chair in the dining room with no carrot splints in her hands. The August 2011 Physician's Recaps included, but was not limited to, orders for "Carrots at all times to hands except for hand cleaning."		**Assistant (CNA) work sheets were reviewed and residents assessed for appropriateness and accuracy of splint usage and splints applied accordingly** **For resident # 43, the care plan and Treatment Record were reviewed and corrected to reflect current physician orders for PICC line dressing and dressing changed accordingly** **For resident # 14 the Medicine Administration Record (MAR) was corrected on 8/30/2011 to reflect accuracy and appropriateness of Insulin Dosage and Administration** **<u>Other residents having the potential to be affected by the same practice</u>** · **All residents having splints, PICC lines and Insulin orders have the potential for being affected by this practice**	

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	A Care Plan for contractures, dated 07/14/11, included an addendum of "...can't tolerate hand splints...approach: change to carrots." The most current MDS [Minimum Data Set Assessment], dated 08/16/11, indicated Resident #31 had impairment to bilateral upper extremities. The undated CNA [Certified Nursing Assistant] assignment sheets Assignment #3, provided by the DoN [Director of Nursing] on 09/21/11 at 2:00 P.M., indicated, "Resident #31 was to have "therapy carrots at all times." In an interview with UM #1, on 09/28/11 at 3:10 P.M., she indicated Resident #31 was to wear the carrots at all times, but "a lot of times she throws them." B. The clinical record of Resident #48 was reviewed on 09/28/11 at 9:15 A.M. The record indicated the resident was a Hospice patient and the diagnoses included, but was not limited to, Parkinson's. Resident #48 was identified by RN #1, during initial tour on 09/21/11 at 11:35 A.M., as not interviewable and having contractures of the bilateral hands.		**and will be identified by Medical Record Reports** **· For these residents, the Physician Orders, Certified Nursing Assistant worksheets, MAR's, Treatment Administration Records (TAR) and Care Plans were reviewed for accuracy** **<u>Measures put into place and systemic changes made</u>** **In - service education for nursing staff regarding use of Care Plans, the necessity of following the care plan for residents who are utilizing splints, have PICC lines and receive insulin** **In – service education presented regarding the transcription of physician orders was presented to all licensed nursing staff** **<u>Corrective actions will be monitored to ensure the practice does not recur</u>**	

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	Resident #48 was observed at that time to be lying in bed with bilateral upper extremity contractures with no splints. Upon query, at that time, RN #1 indicated Resident #48 was holding gauze in her contractures. The August 2011 Physician's Recap included, but was not limited to, an order for "Resident to wear therapy carrots at all times..." The most current MDS [Minimum Data Assessment Set], dated 07/13/11, indicated Resident #48 had bilateral impairment of the upper extremities. Resident #48 was observed on 09/27/11 at 6:00 P.M., lying in bed with bilateral upper extremity contractures, gauze was observed in her hands. Resident #48 was observed on 09/28/11 at 9:40 A.M., lying in bed with bilateral upper extremity contractures, gauze was observed in her hands. The undated CNA assignments sheets Assignment #5, provided by the DoN on 09/21/11 at 2:00 P.M., indicated, "extra info...there [therapy] carrot..." A Care Plan, dated 08/05/10, indicated a problem of "contractures bilateral hands"		**by:** **The DNS, ADNS or designee will complete random checks of physician orders to assure accuracy in transcription of physician orders five (5) times per week times two (2) months and then two (2) times per week times four (4) months** **The DNS, ADNS or designee will complete random checks of the Care Plan and the CNA work sheets to assure accuracy two (2) times per week times six (6) months** **The DNS, ADNS or designee will complete random checks of Physician orders and Treatment Administration Records to assure PICC line dressings are changed and documented accurately five (5) times per week times two months and then two times per week times four (4) months**	

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	with interventions which included, but were not limited to, "keep cloth rolls in hands, ..." In an interview with PT [Physical Therapist] #1, on 09/28/11 at 10:50 A.M., she indicated, "Resident #48 is supposed to have the carrot splints in her hands at all times, except skin care." In an interview with RN #1 on 09/28/11 at 11:00 A.M., she indicated, she had just washed Resident #48's hands and "[Resident #48] should have the larger carrot in her right and the smaller one in her left." RN #1 was then observed to open a drawer and point to a large blue stuffed carrot. RN #1 was then observed to look throughout the room for the smaller carrot and indicated at that time, "I don't know where the smaller one is...I must have thrown it away." RN #1 then indicated, "There is gauze in place for now while her hands are drying." The Policy and Procedure for Application of Removable Preformed Splints, provided by the DoN on 09/29/11 at 9:00 A.M., indicated, "a nurse would...apply a splint according to a physician's order..." In an interview with Hospice Nurse #1, on 09/28/11 at 11:05 A.M., she indicated "[Resident #48] is to have the carrots in		**Findings will be monitored monthly by the Performance Improvement Committee times six (6) months** **Completion Date** **October 24, 2011**	

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	her hands at all times, she has contractures." 2. The clinical record of Resident #43 was reviewed on 09/22/11 at 10:15 A.M. The record indicated, the diagnoses, included, but were not limited to, DVT [Deep Vein Thrombosis] {blood clot} and malnutrition. Resident #43 was identified, during initial tour on 09/21/11 at 12:15 P.M., by UM #1 indicated Resident #43 was interviewable. A Physician telephone order, dated 09/12/11, no time, included an order for "1. Picc [an intravenous catheter]- Flush 10 cc NS every shift 2. change dressing weekly-Picc." A Care plan for the Picc included, but was not limited to, approaches, "change dressing weekly." Resident #43 was observed on 09/22/11 at 2:00 P.M. sitting in the chapel. A Picc line dressing was observed to be intact on the right arm and dated 09/11/11. Resident #43 was observed, on 09/23/11 at 9:45 A.M., sitting in her room. A Picc line dressing was observed to be intact on the right arm dated 09/11/11.			

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	In an interview with the DoN [Director of Nursing], on 09/23/11 at 10:55, she indicated, Resident #43 order for a Picc line dressing change weekly had not been transposed from the admission orders and had not been done as ordered. The policy and procedure for Dressing Change for Vascular Access Devices provided by the DoN on 09/29/11 at 9:00 A.M. indicated, " Purpose To prevent local and systemic infection related to the IV [intravenous] site. Policy...2. Transparent membrane dressings ... are changed every 7 days and PRN [as needed]. 3. The clinical record of Resident #14 was reviewed on 09/22/11 at 2:15 P.M. The record indicated the diagnoses included, but were not limited to, Diabetes Type II. The August 2011 Physician's Order Recap included, but was not limited to, and order			

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	for : "Novolog sliding scale coverage QID [four times a day] -before meals and at hs [hour of sleep]: < [less than] 70=No coverage 70-150=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units > [greater than] 400=10 units and call MD [physician] Use half dose at hs..." The August 2011 Physician's Order Recap page 4 included a handwritten note signed by the physician dated 08/04/11 which indicated, "Start Lantus 10 units at hs..." The August 2011 Medication Administration Record [MAR] lacked any documentation that Lantus 10 units was to be given at bedtime. The Diabetic Monitoring Flow Sheets for August 2011 indicated Resident #14 experienced elevated blood sugars on the following dates" and received insulin per the ordered sliding scale : 08/06/11 at 8:00 P.M. = 498 08/13/11 at 5:00 P.M.= 463 08/13/11 at 7:00 P.M.= "high" 08/20/11 at 4:00 P.M.=432 08/27/11 at 8:00 P.M.=467			

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	A Physician's Telephone Order dated 08/06/11, no time, indicated, "give 15 u [units] of Novolog now-recheck blood sugar in 2 hours-Notify MD if blood sugar >300." A Physician's Telephone Order dated 08/13/11 at 5:30 P.M. indicated, "Recheck BS [blood sugar] in 2 hours...Give total of 15 u Novolog now." A Physician's Telephone Order dated 08/13/11 at 7:30 P.M. indicated, "Give 20 u Novolog now..." A Physician's Telephone Order dated 08/27/11 at 8:30 P.M. indicated, "Give 12 u Novolog now-recheck in 2 hours-if over 400 notify MD again." A Unit 100 Fax dated 08/30/11 indicated, "Noted N.O. [new order] 08/04/11 Lantus 10 units at HS [sic] resident did not receive this medication all mo [month]..." A Medication Variance Report Worksheet provided by the DoN [Director of Nursing] on 09/23/11 at 10:55 A.M. indicated, "Lantus 10 units...No medication given...Adverse Drug Reaction: Yes...Type of Effects observed or reported...Other..." with a handwritten note that indicated, "increased blood sugar resulting in increased coverage...Type of			

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	Variance...Omission..." with a handwritten note that indicated, "Transcription error-order rec'd [received] 8-4-11 not transcribed... Medication Errors Severity Rating...Error; Harm Category E- An error occurred that may have contributed to or resulted in temporary harm to the resident and required intervention." A handwritten notation in the right margin of the worksheet indicated, "[name of physician] wrote order on pink order sheet and not on T.O. [telephone order] Wrote it on 3rd page instead of last." A Care Plan dated 04/20/11 for Type II Diabetes included approaches which included, but was not limited to, "Administer medications as ordered." In an interview with the DoN on 09/23/11 at 10:55 A.M. she indicated, "[name of resident #14] did not get the insulin because the order was not transcribed to the MAR." 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident with a Peripherally Inserted Central Catheter [Picc] line had the dressing changed as ordered (Resident 43), in that Resident #43 had a Picc line dressing change ordered weekly and it was not performed for 1 of 2 residents sampled for IV dressing changes in a facility sample of 22. Findings include: The clinical record of Resident #43 was reviewed on 09/22/11 at 10:15 A.M. The record indicated, the diagnoses, included, but were not limited to, DVT [Deep Vein Thrombosis] {blood clot} and malnutrition. Resident #43 was identified, during initial tour on 09/21/11 at 12:15 P.M., by UM #1 indicated Resident #43 was interviewable. A Physician telephone order, dated 09/12/11, no time, included an order for "1. Picc [an intravenous catheter]- Flush	F0309	**F 329 Angel River Health and Administration Plan of Correction Annual/Complaint Survey Date: September 21, 2011 Indiana State Dept of Health Tag F 329 Corrective Action Taken for those residents found to have been affected** **For resident 20, 68 and 89 the following actions were taken immediately** **Nursing and social services staff assessed each for necessity of medication, behaviors and potential for behaviors** **Pharmacy consultant and resident's physician consulted regarding necessity and appropriateness of medication** **Social Service staff implemented behavior monitoring log on resident 20 monitoring logs were present on resident 68 and resident 89** **Care Plans were updated to reflect specific non pharmaceutical interventions** **Nursing staff instructed to document specific non pharmaceutical interventions**	10/24/2011

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	10 cc NS every shift 2. change dressing weekly-Picc." A Care plan for the Picc included, but was not limited to, approaches, "change dressing weekly." Resident #43 was observed on 09/22/11 at 2:00 P.M. sitting in the chapel. A Picc line dressing was observed to be intact on the right arm and dated 09/11/11. Resident #43 was observed, on 09/23/11 at 9:45 A.M., sitting in her room. A Picc line dressing was observed to be intact on the right arm dated 09/11/11. In an interview with the DoN [Director of Nursing], on 09/23/11 at 10:55, she indicated, Resident #43 order for a Picc line dressing change weekly had not been transposed from the admission orders and had not been done as ordered. The policy and procedure for Dressing Change for Vascular Access Devices provided by the DoN on 09/29/11 at 9:00 A.M. indicated, " Purpose To prevent local and systemic infection related to the IV [intravenous] site. Policy...2. Transparent membrane dressings ... are changed every 7 days and PRN [as needed]. 3.1-37(a)		**attempted to avert behavior before administering medication** **Identify other residents having the potential to be affected by the same practice and corrective actions taken** **All residents receiving psycho active medications are identified by Medical Record Reports Chart reviews will be completed for all residents receiving psycho active medications for: appropriate diagnosis, non-pharmaceutical interventions, and monthly behavior monitoring flow sheet** **Measures put into place and systemic changes to ensure the practice does not recur** **In-services for nursing staff on use and documentation of non-pharmaceutical interventions for residents who receive psycho active medications <u>Corrective actions will be monitored to ensure the practice does not recur by:</u>** **Social Service staff will monitor monthly behavior flow sheets for occurrence of behaviors and presence of specific interventions two (2) times per week times six (6) months Findings will be reviewed by the Performance Improvement Committee monthly times six (6) months** **Completion Date October 24, 2011**	

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F0318 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure residents with contractures had splints applied according to the plan of care (Residents #31 and #48), in that Resident #31 and Resident #48 had carrot splints ordered, but not applied for 2 of 2 residents sampled for splint use in a facility sample of #22. Findings include: 1.A. The clinical record of Resident #31 was reviewed on 09/27/11 at 3:40 P.M. The record indicated diagnoses included, but were not limited to, dementia and bone and cartilage disorder. The record further indicated Resident #31 was receiving Hospice services. Resident #31 was identified, on 09/21/11 11:35 A.M., during the initial tour by UM [Unit Manager] #1 as not interviewable and "having problems with her hands". Resident #31 was observed, at that time, to be lying in bed with two carrot splints lying at her side, her bilateral hands were	F0318	**F 318** **AngelRiverHealth and Rehabilitation** **Plan of Correction** **Annual/Complaint Survey** **Date: September 21, 2011** **IndianaStateDept of Health** **Tag F 318** **Corrective Action Take for those residents found to have been affected** **For resident's #'s 31 and 48 the following actions were taken immediately** ü **Physician orders were checked for splint usage** ü **Care plans and Certified Nursing Assistant (CNA) work sheets were reviewed for**	10/24/2011

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	155670	A. BUILDING 00 B. WING	09/29/2011

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	observed to be contracted. Resident #31 was observed, on 09/27/11 at 11:10 A.M., up in a wheelchair with no carrot splints in her hands. Resident #31 was observed, on 09/27/11 at 5:15 P.M., sitting in a geri-chair in the dining room with no carrot splints in her hands. The August 2011 Physician's Recaps included, but was not limited to, orders for "Carrots at all times to hands except for hand cleaning." A Care Plan for contractures, dated 07/14/11, included an addendum of "...can't tolerate hand splints...approach: change to carrots." The most current MDS [Minimum Data Set Assessment], dated 08/16/11, indicated Resident #31 had impairment to bilateral upper extremities. The undated CNA [Certified Nursing Assistant] assignment sheets Assignment #3, provided by the DoN [Director of Nursing] on 09/21/11 at 2:00 P.M., indicated, "Resident #31 was to have "therapy carrots at all times." In an interview with UM #1, on 09/28/11		**accuracy** **ü Residents were assessed for appropriateness and accuracy of splint usage** **<u>Other residents having the potential to be affected by the same practice;</u>** **· All residents having physician orders for splints have the potential for being affected by this practice and will be identified by Medical Record Reports** **· For these residents the following actions were taken:** **ü Physician Orders, CNA worksheets, Treatment Records and Care Plans were reviewed for accuracy** **ü Observations were made to assure accurate application of splints and resident compliancy with splints** **<u>Measures put into place</u>**	

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	at 3:10 P.M., she indicated Resident #31 was to wear the carrots at all times, but "a lot of times she throws them." B. The clinical record of Resident #48 was reviewed on 09/28/11 at 9:15 A.M. The record indicated the resident was a Hospice patient and the diagnoses included, but was not limited to, Parkinson's. Resident #48 was identified by RN #1, during initial tour on 09/21/11 at 11:35 A.M., as not interviewable and having contractures of the bilateral hands. Resident #48 was observed at that time to be lying in bed with bilateral upper extremity contractures with no splints. Upon query, at that time, RN #1 indicated Resident #48 was holding gauze in her contractures. The August 2011 Physician's Recap included, but was not limited to, an order for "Resident to wear therapy carrots at all times..." The most current MDS [Minimum Data Assessment Set], dated 07/13/11, indicated Resident #48 had bilateral impairment of the upper extremities. Resident #48 was observed on 09/27/11 at 6:00 P.M., lying in bed with bilateral		**and systemic changes made** **In - service education for nursing staff regarding residents' plan of care for splint placement and necessity for following the care plan** **Corrective actions will be monitored to ensure the practice does not recur by:** **DNS, ADNS or designee will randomly observe the application of splints and resident compliance two (2) times per week times six (6) months** **DNS, ADNS or designee will randomly check the Care Plan and CNA work sheets for accuracy two (2) times per week times six (6) months** **Findings will be monitored by the Performance Improvement Committee times six (6) months** **Completion Date**	

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	upper extremity contractures, gauze was observed in her hands. Resident #48 was observed on 09/28/11 at 9:40 A.M., lying in bed with bilateral upper extremity contractures, gauze was observed in her hands. The undated CNA assignments sheets Assignment #5, provided by the DoN on 09/21/11 at 2:00 P.M., indicated, "extra info...there [therapy] carrot..." A Care Plan, dated 08/05/10, indicated a problem of "contractures bilateral hands" with interventions which included, but were not limited to, "keep cloth rolls in hands, ..." In an interview with PT [Physical Therapist] #1, on 09/28/11 at 10:50 A.M., she indicated, "Resident #48 is supposed to have the carrot splints in her hands at all times, except skin care." In an interview with RN #1 on 09/28/11 at 11:00 A.M., she indicated, she had just washed Resident #48's hands and "[Resident #48] should have the larger carrot in her right and the smaller one in her left." RN #1 was then observed to open a drawer and point to a large blue stuffed carrot. RN #1 was then observed to look throughout the room for the		**October 24, 2011**	

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	smaller carrot and indicated at that time, "I don't know where the smaller one is...I must have thrown it away." RN #1 then indicated, "There is gauze in place for now while her hands are drying." The Policy and Procedure for Application of Removable Preformed Splints, provided by the DoN on 09/29/11 at 9:00 A.M., indicated, "a nurse would...apply a splint according to a physician's order..." In an interview with Hospice Nurse #1, on 09/28/11 at 11:05 A.M., she indicated "[Resident #48] is to have the carrots in her hands at all times, she has contractures." 3.1-42(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure 1 of 8 sampled residents reviewed for falls, in the total sample of 22, had alarms placed out of reach to ensure she could not disable them, so that they would alert staff if she got up unattended. (Resident D)	F0323	**F 323** **AngelRiverHealth and Rehabilitation** **Plan of Correction** **Annual/Complaint Survey** **Date: September 21, 2011** **IndianaStateDept of**	10/24/2011

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	Finding includes: Resident D's clinical record was reviewed on 9/27/11 at 4:00 p.m. The resident's last completed full Minimum Data Set [MDS] assessment, dated 6/17/11, indicated she had experienced falls with no injuries. The care plan, dated 8/23/10, indicated the resident would turn off and/or hide alarms. Interventions included, but were not limited to, "keep alarms out of reach." Nurses' notes included, but were not limited to, the following: 8/9/11 0630 [6:30 a.m.] "Found sitting on btx [buttocks] on floor mat, next to her bed. Upon questioning res., admitted to turning off her pressure alarm per self...res. has history of non-compliance [with] alarms..." 9/8/11 9:50 a.m., "Resident states she scooted across floor this a.m. to BR [bathroom] on buttocks denies injury...CNA verified events." 9/11/11 11:00 a.m., "Resident fall from w/c [wheelchair] into her bed...abrasion noted (R) [right] et (L) [left] knees..." 9/12/11 9:00 a.m., Incident from 9/11/11 not considered a fall. Resident had purposeful movement from w/c to bed. Did get abrasions on bilateral knees when transferring." On 9/27/11 at 5:05 p.m., Resident D was		**Health** **Tag F 323** **Corrective action taken for those residents found to have been affected** **For resident D, alarms were assessed for appropriate placement and the resident's level of compliance with the alarms** **The resident's care plan was updated to reflect the type and placement of alarms** **Identification of other residents having the potential to be affected by the practice and corrective actions taken** **Residents who have orders for alarms are identified by Medical Record Reports** **All residents who have physician orders for alarms will be assessed for appropriateness of alarms and accurate**	

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	observed in her wheelchair in the hallway. The alarm box was hanging on the upper right handle of the resident's wheelchair, within reach of the resident. On 9/28/11 at 4:45 p.m., Resident D was observed in her wheelchair, halfway into the resident's bathroom in her room. The alarm box was hanging on the upper right handle of the wheelchair, in reach of the resident. The CNA assignment sheet, provided by the Director of Nurses on 9/21/11 at 2:00 p.m., indicated, for Resident D, "keep alarm box out of reach." During an interview on 9/29/11 at 10:00 a.m., the Director of Nurses indicated the alarm box should be kept out of reach of the resident. This federal tag relates to complaint number IN00096312. 3.1-45(a)(2)		**placement and level of compliance with alarms Care Plans, Treatment Administration Records, Certified Nursing Assistant worksheets of all residents who have physician orders for alarms will be reviewed and updated to reflect alarm usage** **Measures in place and systemic changes made to ensure the practice does not recur** **Nursing staff will be in-serviced regarding the use of alarms as to placement, resident compliance and appropriateness of the alarm** **Corrective actions will be monitored to ensure the practice does not recur by:** **DNS, ADNS or designee will randomly observe resident alarm placement and resident compliance**	

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			two (2) times per week times six (6) months Findings will be monitored by the Performance Improvement Committee times six (6) months **Completion Date** **October 24, 2011**	
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure residents were free of unnecessary medications (Resident #20, Resident #68, Resident #89), in that residents received	F0329	**F 329 Angel River Health and Administration Plan of Correction Annual/Complaint Survey Date: September 21, 2011 Indiana State Dept of Health Tag F 329 Corrective**	10/24/2011

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	psychoactive medications without staff first attempting nonpharmacologic interventions or adequate monitoring for 3 of 14 residents sampled for psychoactive medications in the sample of 22. Findings include: 1. The clinical record for Resident #20 was reviewed on 09/28/11 at 9:45 A.M. Resident #20 was observed on 09/28/11 at 10:00 A.M. lying in bed. The most current MDS [Minimum Data Set Assessment] dated 07/07/11 indicated Resident #20 was moderately cognitively impaired. The MDS further indicated a behavior of hitting had been identified. A fax provided by the DoN on 09/27/11 at 10:30 A.M. included a handwritten Physician's order dated 04/22/11 indicated, "Vistaril 25 mg [milligram] by mouth [BID] twice daily as needed aggitation [sic]/anxiety" The MAR [Medication Administration Record] for April 2011 indicated Vistaril 25 mg had been given twice on 04/23/11, twice on 04/24/11, and once on 04/28/11. The back of the MAR on the Nurse's Medication Notes included, but was not limited to, the following notations:		**Action Taken for those residents found to have been affected For resident 20, 68 and 89 the following actions were taken immediately Nursing and social services staff assessed each for necessity of medication, behaviors and potential for behaviors Pharmacy consultant and resident's physician consulted regarding necessity and appropriateness of medication Social Service staff implemented behavior monitoring log on resident 20 monitoring logs were present on resident 68 and resident 89** **Care Plans were updated to reflect specific non pharmaceutical interventions** **Nursing staff instructed to document specific non pharmaceutical interventions attempted to avert behavior before administering medication** **Identify other residents having the potential to be affected by the same practice and corrective actions taken** **Identify other residents having the potential to be affected by**	

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	"04/23/11 at 0940 [9:40 A.M.] Vistaril 25 mg by mouth for yelling/anxious... Response sleeping 10:30 A.M. 04/24/11 at 0730 [7:30 A.M.] Vistaril 25 mg by mouth for yelling/anxious...[No response documented]" 04/24/11 2100 [9:00 A.M.] Vistaril 25 mg by mouth for no sleeping...[No response documented]..." 04/28/11 0530 [5:30 A.M.] Vistaril 25 mg by mouth for attempting to get OOB [out of bed] and increased agitation... Response: up in chair, decreased agitation 0630 [6:30 A.M.]" The Nurse's Medication Notes lacked any documentation that more than one dose of Vistaril was administered on 04/23/11. The Nurse's Notes included the following entries: "04/23/11 0345 [3:45 A.M.] ...Refused Vistaril at MN [midnight] as offered by nurse to help with anxiety." The note lacked any documentation that nonpharmacological interventions were attempted before the medication was offered. "04/23/11 1030 [10:30] ...prn [as needed] Vistaril given et [and] helpful..." The note lacked any documentation that nonpharmacological interventions were attempted before the medication was		**the same practice and corrective actions taken All residents receiving psycho active medications are identified by Medical Record Reports Chart reviews will be completed for all residents receiving psycho active medications for: appropriate diagnosis, non-pharmaceutical interventions, and monthly behavior monitoring flow sheet Measures put into place and systemic changes to ensure the practice does not recur In-services for nursing staff on use and documentation of non-pharmaceutical interventions for residents who receive psycho active medications Corrective actions will be monitored to ensure the practice does not recur by: Social Service staff will monitor monthly behavior flow sheets for occurrence of behaviors and presence of specific interventions two (2) times per week times six (6) months Findings will be reviewed by the Performance Improvement Committee monthly times six (6) months Completion Date October 24, 2011**	

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	administered. "04/24/11 10:15 [1:;15 A.M.] ...prn Vistaril given as needed..." The note lacked any documentation that nonpharmacological interventions were attempted before the medication was administered. The Nursing Notes lacked any further documentation on 04/24/11 related to the Vistaril. "04/28/11 0600 [6:00 A.M.] Resident slept in bed approx [approximately] 1 1/2-2 hrs [hours] and was given Visteril [sic] 25 mg by mouth d/t [due to] while up in wheelchair attempting to scoot down out of chair with bed alarm sounding. While in room kept attempting to sit on side of bed causing alarm to sound. While resident sitting at nurse's station and this nurse attempting to reposition legs pulled staff's hair and stated, "do something with that hair!" Offered juice and consumed 120 cc cranberry juice...After Visteril [sic] admin [administered] became quiet and napped for very short period." A fax to the physician, dated 04/25/11 was provided by the DoN on 09/28/11 at 10:30 A.M. and indicated, "Fam. [Family] requesting to change Visteril [sic] to BID [twice daily] routine instead of prn [as			

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	needed]. Says they see an improvement [sic] since started..." The physician's response included had handwritten order for, "Vistaril 25 mg [milligram] by mouth [BID] twice daily as needed aggitation [sic]/anxiety" The Resident Progress Notes dated 04/20/11 through 04/30/11 were reviewed and lacked any Social Service documentation. The clinical record lacked any documentation of a plan of care for behaviors. In an interview with the SSD [Social Services Designee] on 09/28/11 at 4:45 P.M. she indicated, "Psychoactive monitoring record, not found on [name of Resident #20]." In an interview with the DoN [Director of Nursing] on 09/28/11 at 12:10 P.M. she indicated multiple interventions were attempted prior to receiving the prn Vistaril order, but a formal plan had not been created. The DoN further indicated at that time that Resident #20 had later been treated for a UTI [urinary tract infection] and was no longer exhibiting the behaviors. In an interview with the HFA [Health Facilities Administrator] on 09/28/11 at 4:45 P.M. she indicated, "As far as a			

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	behavior plan, it's just not there." The Policy and Procedure for Psychoactive Drug Use provided by the DoN on 09/29/11 at 09:00 A.M. indicated, "...Procedure...5. Implement a behavior monitoring log or similar mechanisms to document need for and response to drug therapy. 6. Identify evidence for other possible reasons for the patient's distress has been considered and ruled out. This may include, but is not limited to"... a. pain b. Environmental stressors... c. Psychosocial stressors... d. Treatable medical conditions... e. Infection... 10. Attempt alternative methods to psychoactive drug use and document effectiveness... 15. Collaborate with the physician in considering whether the current medication, dose, and duration (e.g. medication was initiated as a result of a time-limited condition such as an infection and then should be discontinued) is appropriate or should be reduced, changed, or discontinued...Documentation Guidelines...4. Document evaluation of patient response to psychoactive drug, effectiveness of psychoactive drug, dose reductions (effectiveness or failure), factor and/or complications related to			

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	psychoactive drug use. Update care plan as needed...." 2. Resident #68's clinical record was reviewed on 9/26/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, arthritis, Alzheimer's disease, anxiety and depression. Review of the Medication Administration Record [MAR] for September, 2011, at the time of the record review, indicated Ativan 0.25 milligrams [mg] was administered on the following dates and times, for "yelling, agitated," "yelling/anxiety," "screaming," or "anxiety [increased]:" 9/1/11 1:30 p.m. 9/1/11 10:40 p.m. 9/2/11 2:30 p.m. 9/5/11 9:00 p.m. 9/8/11 8:00 p.m. 9/11/11 8:30 p.m. 9/13/11 9:30 p.m. 9/18/11 5:00 p.m. 9/19/11 9:30 a.m. 9/25/11 9:00 p.m. Review of the Monthly Behavior Monitoring Flowsheet and nurses' notes for September, 2011, indicated the following interventions documented as attempted on the above dates and times:			

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	9/1/11 redirection 9/2/11 none 9/5/11 redirection and medication 9/8/11 redirection and one to one care 9/11/11 none 9/13/11 redirection, one to one care, medication 9/18/11 none 9/19/11 redirection, medication 9/25/11 redirection Also noted, in the clinical record, the resident was started on an antibiotic for pneumonia on 9/18/11. The resident's care plan, dated 9/7/2009, indicated a problem of restless/worried/anxious behaviors at times "yells out and is tearful at times-confusion at times-has had overall decline in mental state." Interventions included, but were not limited to, the following: "Remain with resident during stressful periods and report. Set up a consistent schedule for daily care... Provide positive reinforcement when not anxious. Assess and document frequency of anxiety. Assess for drugs/contributing factors which cause anxiety and intervene as needed.			

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	Encourage discussion of fear/anxiety. Allow to cry. Report tears/crying. Call Daughter if unable to calm resident. Administer meds as ordered. Assess for S/S [signs/symptoms] of infection and obtain labs as ordered. Rule out pain, hungar (sic), thirst." Nurses' notes included, but were not limited to, the following: 9/5/11 10:00 a.m., "Res. refused to lay down for a nap tried to redirect res. unsuccessful...Res. yelling 'I want to get out of here, I'm going to tell my Daddy on you.'" 9/5/11 1:50 p.m., "Res. refused to lay back down after meal and tried to encourage res. but she still saying 'No'..." 9/5/11 2:00 p.m. "Attempt to lay res. down again res. in agreement after 30 mins res. started yelling real loud and spelling out letters of the alphabet tried to redirect res. but wasn't successful." 9/6/11 12:00 midnight, "Up...d/t [due to] resident was in her bed and kept yelling loudly, 'gotta get up' over and over. 1 on 1 X's multiple attempts non-successful. Routine 2400 [midnight] med (ativan 0.5 mg [antianxiety medication]) administered as ordered. Appeared more calm, but refusing to go back to her bed. Given magazine et a snack." 9/6/11 5:00 a.m., "Resident has refused to go back to bed X's numerous			

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	attempts...Now is screaming loudly 'I'm gonna just call the police on you.' Noted [increased] anxiety and when this writer asks if she is hurting yells out -" yes all the time - everywhere." PRN [as needed] Lortab [pain medication] and PRN ativan administered @ this time." 9/8/11 2400, "[increased] anxiety, yelling out in bed. Routine Ativan and PRN Lortab administered at the time." 9/9/11 9:30 a.m., "Res. assisted to bed, res. started yelling et crying stating, 'I want to go home, I want to get up.' Tried to redirect res. unsuccessful notify M.D. to see if he would [increase] Risperdal [antipsychotic medication] to T.I.D. [three times a day." 9/12/11 1:55 a.m., "Yelling out, offered bologna/cheese sandwich, consumed 100% with assist, drank 180 ml [milliliters] milk, 80 ml H2O [water], will monitor." 9/12/11 2:55 a.m., "Resting in bed [with] eyes closed, no s/s of distress." Social Service notes included, but were not limited to, the following: 9/7/11 [no time] "...met with resident's [family] re: recent [change] in mood/behavior and med [medication] review...Discussed possible progression and options of [inpatient psychiatric unit] eval in future if physician feels he is unable to manage her @ facility."			

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	9/14/11 [no time] "...She has had a [change] in mood/behavior since last assessment as she has been restless, tearful and yells out...She will become tearful and state, 'I want to go home,' or she looks for her father/mother and thinks they have left her...Physician has [increased] her medicine to Risperdal. This has been effective [with] her behavior. She has been less alert early in the a.m. according to nursing, however, becomes more alert as the morning goes by but is calm. She also utilizes Ativan for anxiety..." Nurses' notes continued: 9/16/11 10:00 p.m., Res. very agitated - yelling and crying - Ativan given for agitation [and] Lortab for c/o [complaint of] pain - Sleeping." 9/17/11 6:00 p.m., "[Family] concerned that pt. isn't as 'alert' today..." 9/18/11 Condition Change Form, [no time], CXR [chest x-ray] results indicate pneumonia - rec'd [received] order for [antibiotic]..." 9/19/11 9:30 a.m., "Res. yelling and crying wanting to leave - tried to redirect res. unsuccessful gave Ativan 0.25 mg per M.D. order." 9/23/11 9:00 p.m., "Quiet most of the shift - did cry out for a short while after going to bed, but not for long." 9/24/11 10:30 p.m., "Yells out loudly @			

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	times, given cookies/milk [with] good effect, denies pain, will observe..." 3. Resident #89's clinical record was reviewed on 9/23/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to, history of urinary tract infections, hypertension, diabetes mellitus, history of delirium, anxiety and depression. The resident had a care plan, dated 9/17/11, for anxiety. The interventions included, but were not limited to, the following: "Find a calm, quiet environment. Reassure during interactions by touch and verbal/non verbal exchanges. Assess for drugs which cause anxiety. Administer medication as ordered...Monitor effectiveness [and] side effects. Remain with resident during stressful periods and report. Hospice to assess for anxiety. Obtain labs as ordered." Review of the September, 2011 Medication Administration Record [MAR] indicated Ativan [anti-anxiety medication] .25 milligrams [mg] was given on the following dates and times for "anxiety:" 9/18/11 12:00 noon			

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	9/21/11 8:00 p.m. 9/22/11 4:30 a.m. 9/22/11 6:00 p.m. 9/26/11 4:00 p.m. Nurses' notes included, but were not limited to, the following: 9/15/11 11:00 a.m., "Agitation noted this shift..." 9/19/11 [no time] Condition Change Form, "per family request -- MD ordered UA C + S [urinalysis, culture and sensitivity]." 9/20/11 8:15 p.m., "Initial dose of Atb [antibiotic] started...restless up in w/c [wheelchair] for eve [evening] meal..." 9/21/11 2:15 p.m., "ATB UTI [urinary tract infection] continues resident restless today...resident assisted to bed resting [with] eyes closed." 9/21/11 9:00 p.m., "Tearful @ times this shift. C/O [complaint of] pain, Lortab [pain medication] effective. Ativan given for [increased] anxiety helpful alarm placed..." 9/22/11 10:40 a.m., "ATB UTI continues resident agitated this AM. Ref. [refused] breakfast fidgety in recliner speech difficult to understand @ times but able to tell staff she wanted to go back to bed assisted..." 9/22/11 8:20 p.m., "Noted N.O. [new order] for Rocephin [antibiotic] 1 gm [gram] IM [intramuscularly] qd [daily] X			

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	7 days (UTI)..." Resident #89 had a Monthly Behavior Monitoring flowsheet for September, 2011. The target behavior identified on the flowsheet was "S/S [signs/symptoms] Depression." There was no monitoring for anxiety, no documentation of interventions attempted prior to using the anti-anxiety medication. 3.1-48(a)(3) 3.1-48(a)(4)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents receiving insulin were free of significant medication errors (Resident #14), in that Resident #14 had insulin ordered at bedtime and it was not given for 26 days, for 1 of 2 residents sampled for receiving insulin in a facility sample of 22. Findings include: The clinical record of Resident #14 was	F0333	**F 333** **AngelRiverHealth and Rehabilitation** **Plan of Correction** **Annual/Complaint Survey Date: September, 21, 2011** **IndianaStateDept of Health** **Corrective action taken for those residents found**	10/24/2011

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	reviewed on 09/22/11 at 2:15 P.M. The record indicated the diagnoses included, but were not limited to, Diabetes Type II. The August 2011 Physician's Order Recap included, but was not limited to, and order for : "Novolog sliding scale coverage QID [four times a day] -before meals and at hs [hour of sleep]: < [less than] 70=No coverage 70-150=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units > [greater than] 400=10 units and call MD [physician] Use half dose at hs..." The August 2011 Physician's Order Recap page 4 included a handwritten note signed by the physician dated 08/04/11 which indicated, "Start Lantus 10 units at hs..." The August 2011 Medication Administration Record [MAR] lacked any documentation that Lantus 10 units was to be given at bedtime. The Diabetic Monitoring Flow Sheets for August 2011 indicated Resident #14 experienced elevated blood sugars on the following dates" and received insulin per the ordered sliding scale :		**to have been affected** **Actions taken for Resident # 14 immediately were:** **Assessed for adverse reactions** **Diabetic flow sheets were reviewed to assess for accuracy in medication administration and blood sugar levels** **Medication Administration Record was reviewed for accuracy in administration of medications** **Medical record was reviewed for documentation of the med error and appropriate follow up at the time of the med error** **Other residents having the potential to be affected by the same practice:** **Residents who have Insulin orders are identified by Medical Records Reports** **All residents receiving**	

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	08/06/11 at 8:00 P.M. = 498 08/13/11 at 5:00 P.M.= 463 08/13/11 at 7:00 P.M.= "high" 08/20/11 at 4:00 P.M.=432 08/27/11 at 8:00 P.M.=467 A Physician's Telephone Order dated 08/06/11, no time, indicated, "give 15 u [units] of Novolog now-recheck blood sugar in 2 hours-Notify MD if blood sugar >300." A Physician's Telephone Order dated 08/13/11 at 5:30 P.M. indicated, "Recheck BS [blood sugar] in 2 hours...Give total of 15 u Novolog now." A Physician's Telephone Order dated 08/13/11 at 7:30 P.M. indicated, "Give 20 u Novolog now..." A Physician's Telephone Order dated 08/27/11 at 8:30 P.M. indicated, "Give 12 u Novolog now-recheck in 2 hours-if over 400 notify MD again." A Unit 100 Fax dated 08/30/11 indicated, "Noted N.O. [new order] 08/04/11 Lantus 10 units at HS [sic] resident did not receive this medication all mo [month]..." A Medication Variance Report Worksheet provided by the DoN [Director of Nursing] on 09/23/11 at 10:55 A.M.		**Insulin will have clinical records checked for:** **Physician orders for insulin** **Accuracy in transcription of physician orders for insulin** **Accuracy in administration of insulin** **Accuracy in documentation of insulin administration** **Measures put into place and systemic changes made** **In - service education for all licensed nurses regarding the Transcription of physician orders for insulin Administration and documentation of insulin** **Corrective actions will be monitored to ensure the practice does not recur by:** **The DNS, ADNS or designee will do random checks (2) times per week times two (2) months and**	

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	indicated, "Lantus 10 units...No medication given...Adverse Drug Reaction: Yes...Type of Effects observed or reported...Other..." with a handwritten note that indicated, "increased blood sugar resulting in increased coverage...Type of Variance...Omission..." with a handwritten note that indicated, "Transcription error-order rec'd [received] 8-4-11 not transcribed... Medication Errors Severity Rating...Error; Harm Category E- An error occurred that may have contributed to or resulted in temporary harm to the resident and required intervention." A handwritten notation in the right margin of the worksheet indicated, "[name of physician] wrote order on pink order sheet and not on T.O. [telephone order] Wrote it on 3rd page instead of last." A Care Plan dated 04/20/11 for Type II Diabetes included approaches which included, but was not limited to, "Administer medications as ordered." In an interview with the DoN on 09/23/11 at 10:55 A.M. she indicated, "[name of resident #14] did not get the insulin because the order was not transcribed to the MAR." 3.1-25(b)(9) 3.1-48(c)(2)		**then monthly times six (6) months for those residents who receive insulin. The clinical records will be checked for:** **Physician orders** **Accurate and timely transcription of orders** **Accurate and timely administration of the medication** **The Performance Improvement Committee will monitor findings of random checks monthly times six (6) months** **Completion Date** **October 24, 2011**	

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			

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	Based on observation, interview, and record review, the facility failed to ensure policies and procedures for infection control were implemented for 4 of 8 sampled residents observed for medications, treatments/dressing changes, perineal care, in the sample of 22, in that a Peripherally Inserted Central Catheter [PICC] line dressing was not changed as ordered, hands were not washed between residents being administered medications, and perineal care was done in a way that put the resident at risk for infection. (Residents #43, #8, #20, #118) Findings include: 1. The clinical record of Resident #43 was reviewed on 09/22/11 at 10:15 A.M. The record indicated, the diagnoses, included, but was not limited to, DVT [Deep Vein Thrombosis] and malnutrition. Resident #43 was identified by the UM [Unit Manager] #1 on 09/21/11 at 12:15 A.M. during initial tour as interviewable. A Physician telephone order dated, 09/12/11 no time indicated, included an order for "1. Picc [an intravenous catheter]- Flush 10 cc NS [normal saline] every shift 2. change dressing weekly-Picc."	F0441	**F 441 Angel River Health and Rehabilitation Plan of Correction Annual/Complaint Survey Date: September 21, 2011 Indiana State Dept of Health <u>Corrective action taken for those residents found to have been affected</u>** **Resident # 43 the following actions were taken immediately:** **The physician order was checked** **The PICC line dressing was changed following physician order** **The PICC line site was assessed for signs and symptoms of infection** **The physician was notified** **Resident # 's 8 and 20 the following actions were taken immediately:** **Observations were made for adverse reactions to the omission of hand washing between the two residents** **RN # 2 was counseled regarding the facility policy and infection control principle of hand washing between resident contact** **Resident # 118 the following actions were taken immediately:** **Observations were made for any adverse reactions** **Perineal care was given following facility policy and infection control principles**	10/24/2011

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	The Care plan for the Picc included, but was not limited to, approaches, "change dressing weekly." Resident #43 was observed on 09/22/11 at 2:00 P.M. sitting in the chapel. A Picc line dressing was observed to be intact on the right arm and dated 09/11/11. Resident #43 was observed on 09/23/11 at 9:45 A.M. sitting in her room. A Picc line dressing was observed to be intact on the right arm dated 09/11/11. The policy and procedure for Dressing Change for Vascular Access Devices provided by the DoN [Director of Nursing] on 09/29/11 at 9:00 A.M. indicated, " Purpose To prevent local and systemic infection related to the IV [intravenous] site. Policy...2. Transparent membrane dressings ... are changed every 7 days and PRN [as needed]. In an interview with the DoN on 09/23/11 at 10:55 she indicated, the admission order for the Picc line dressing change had not been transposed and had not been done as ordered. 2. During the observation of a medication pass, on 09/27/11 at 4:20 P.M., RN #2 was observed to prepare and administer medication to Resident #8. RN #2 was		**CNA # 1 was counseled regarding the necessity of following facility policy and infection control principles when giving perineal care** **Other residents having the potential to be affected by the same practice:** **All residents who receive peritoneal care, have PICC lines and are given medications have the potential to be affected. For those residents the following actions have been taken:** **Infection control data has been reviewed to assess for trends/patterns of increased Urinary Tract infections and other infectious processes, i.e. respiratory, gastrointestinal, etc.** **In - services on necessity for hand washing after each patient contact have been presented to all nursing staff who administer medications** **In – services on peritoneal care and necessity to use infection control methods according to facility policy have been presented to all nursing staff who give peritoneal care** **In – services on PICC line dressing changes and infection control principles have been presented to all licensed nursing staff** **Corrective actions will be monitored to ensure the**	

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	155670	A. BUILDING 00 B. WING	09/29/2011

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	then observed to touch the forearm of Resident #8. RN #2 was then observed to prepare and administer medications to Resident #20 (sampled resident) without performing handwashing. The policy and procedure for Hand Hygiene/ Handwashing provided by the DoN on 09/29/11 at 9:00 A.M. indicated, " Rationale,...Hand Hygiene is to be performed...between patient contacts..." In an interview with RN #3 on 09/27/11 at 4:30 P.M. she indicated, "We are to wash hands before every patient." 3. On 9/27/11 at 10:15 a.m., Resident #118 was observed laying in bed. She complained of hurting on her bottom. The call light was activated and CNA #1 answered the light. CNAs #1 and #2 were observed cleansing the resident and changing the resident's incontinence brief. The resident was observed to have a urinary catheter; she had been incontinent of bowel into the brief. CNA #1 initially cleansed the resident's buttocks and anal area. The buttocks and anal area were observed to be reddened. CNA #1		**practice does not recur by:** **The Staff Development Coordinator, DNS or ADNS and/or designee will observe two (2) medication passes per week times six (6) months** **The Staff Development Coordinator, DNS, ADNS and/or designee will observe peritoneal care being given two (2) times per week times six (6) months** **The Staff Development Coordinator will Collect and Analyze monthly Infection Control data to identify increased infections** **Infection Control findings and results of observations will be reviewed by the Performance Improvement Committee monthly times six (6) months** **Completion Date** **October 24, 2011**	

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	changed gloves and washed her hands. She then proceeded to cleanse the front perineal area of the resident. She used a wash cloth with soap on it, reached between the resident's legs and washed from the back of the perineal area to the front, where the catheter exited the urethra. She washed from back to front, then rinsed from back to front. Resident #118's clinical record was reviewed on 9/27/11 at 11:00 a.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, history of urinary tract infections, dementia, anxiety, and a history of Clostridium Difficile infection. The resident was currently receiving Flagyl [anti-fungal medication] and Vancomycin [antibiotic] for chronic recurrent Clostridium Difficile, a bowel infection. The Director of Nurses [DoN] provided a copy of the procedure for Perineal Care for the Female Resident, dated 4/28/07, on 9/29/11 at 9:00 a.m. The procedure included, but was not limited to, the following instruction: "Gently cleanses the pubic area: a. Uses one gloved hand to stabilize and separate the labia and use the other hand to wash from front to back. b. Cleanses from front to back..."			

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	The observation was reviewed with the Administrator and DoN on 9/27/11 at 6:20 p.m. The DoN indicated, during interview, they would have to review the procedure with CNA #1, to always cleanse front to back in the perineal area. 3.1-18(b)(1)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure residents receiving insulin were free of significant medication errors (Resident #14), in that Resident #14 had a new order for insulin at bedtime, it was not transcribed in a timely manner resulting in the resident not receiving the ordered insulin for 26 days, for 1 of 2 residents sampled for receiving insulin in a facility sample of 22.	F0514	**F 514** **AngelRiverHealth and Rehabilitation** **Plan of Correction** **Annual/Complaint Survey** **Date: September, 21, 2011** **IndianaStateDept of Health**	10/24/2011

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	Findings include: The clinical record of Resident #14 was reviewed on 09/22/11 at 2:15 P.M. The record indicated the diagnoses included, but were not limited to, Diabetes Type II. The August 2011 Physician's Order Recap included, but was not limited to, and order for : "Novolog sliding scale coverage QID [four times a day] -before meals and at hs [hour of sleep]: < [less than] 70=No coverage 70-150=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units > [greater than] 400=10 units and call MD [physician] Use half dose at hs..." The August 2011 Physician's Order Recap page 4 included a handwritten note signed by the physician dated 08/04/11 which indicated, "Start Lantus 10 units at hs..." The August 2011 Medication Administration Record [MAR] lacked any documentation that Lantus 10 units was to be given at bedtime. The Diabetic Monitoring Flow Sheets for		**Corrective action taken for those residents found to have been affected** **Resident # 14 was:** **Assessed for adverse reactions** **Diabetic flow sheets were reviewed to assess for accuracy in medication administration and blood sugar levels** **Medication Administration Record was reviewed for accuracy in administration of medications** **Medical record was reviewed for documentation of the med error and appropriate follow up at the time of the med error** **Other residents having the potential to be affected by the same practice:** **Residents who have Insulin orders are identified by Medical Records Reports**	

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	August 2011 indicated Resident #14 experienced elevated blood sugars on the following dates" and received insulin per the ordered sliding scale : 08/06/11 at 8:00 P.M. = 498 08/13/11 at 5:00 P.M.= 463 08/13/11 at 7:00 P.M.= "high" 08/20/11 at 4:00 P.M.=432 08/27/11 at 8:00 P.M.=467 A Physician's Telephone Order dated 08/06/11, no time, indicated, "give 15 u [units] of Novolog now-recheck blood sugar in 2 hours-Notify MD if blood sugar >300." A Physician's Telephone Order dated 08/13/11 at 5:30 P.M. indicated, "Recheck BS [blood sugar] in 2 hours...Give total of 15 u Novolog now." A Physician's Telephone Order dated 08/13/11 at 7:30 P.M. indicated, "Give 20 u Novolog now..." A Physician's Telephone Order dated 08/27/11 at 8:30 P.M. indicated, "Give 12 u Novolog now-recheck in 2 hours-if over 400 notify MD again." A Unit 100 Fax dated 08/30/11 indicated, "Noted N.O. [new order] 08/04/11 Lantus 10 units at HS [sic] resident did not receive this medication all mo [month]..."		**All residents receiving Insulin will have clinical records checked for:** **Physician orders for insulin** **Accuracy in transcription of physician orders for insulin** **Accuracy in administration of insulin** **Accuracy in documentation of insulin administration** **Measures put into place and systemic changes made** **In - service education will be presented for all licensed nurses regarding the** **Transcription of physician orders for insulin** **Administration and documentation of insulin** **Corrective actions will be monitored to ensure the practice does not recur by:** **The DNS, ADNS or designee will do random**	

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	A Medication Variance Report Worksheet provided by the DoN [Director of Nursing] on 09/23/11 at 10:55 A.M. indicated, "Lantus 10 units...No medication given...Adverse Drug Reaction: Yes...Type of Effects observed or reported...Other..." with a handwritten note that indicated, "increased blood sugar resulting in increased coverage...Type of Variance...Omission..." with a handwritten note that indicated, "Transcription error-order rec'd [received] 8-4-11 not transcribed... Medication Errors Severity Rating...Error; Harm Category E- An error occurred that may have contributed to or resulted in temporary harm to the resident and required intervention." A handwritten notation in the right margin of the worksheet indicated, "[name of physician] wrote order on pink order sheet and not on T.O. [telephone order] Wrote it on 3rd page instead of last." A Care Plan dated 04/20/11 for Type II Diabetes included approaches which included, but was not limited to, "Administer medications as ordered." In an interview with the DoN on 09/23/11 at 10:55 A.M. she indicated, "[name of resident #14] did not get the insulin because the order was not transcribed to the MAR."		**checks on those residents who have physician orders for Insulin (2) times per week times six (6) months The clinical records will be checked for accuracy in the following:** **Physician orders** **Diabetic flow sheets** **Transcription of orders** **Administration of the medication** **The Performance Improvement Committee will monitor findings of random checks monthly times six (6) months** **<u>Completion Date</u>** **October 24, 2011**	

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	3.1-50(a)(2)			